

# CLINICAL GOVERNANCE

## Bulletin

### Editorial: Knowledge management

**Myriam Lugon<sup>1</sup> and Gabriel Scally<sup>2</sup>**

<sup>1</sup> *Consultant, Clinical Governance and Health Care Policy, London;*

<sup>2</sup> *Regional Director of Public Health, NHS Executive South West, Bristol*

Achieving continuous improvement in the quality of care delivered in the NHS is what lies behind successful clinical governance. To progress this agenda, health-care organisations need to focus on patients and their care needs, and to ensure that the staff they employ have the right skills and competencies to deliver that care. To this end they need to invest in training and development. In devising staff development programmes, the principles described in *Continuous Professional Development*<sup>1</sup> should be adopted. These include the need:

- to be patient centred (that is, linking any programme to what really matters to patients);
- to build on previous knowledge, skills and experience;
- to focus on the development of clinical teams.

Organisations must create a learning environment – that is, one that

encourages clinical teams and individuals to learn from what they do and improve matters as a result of that learning; they also need to establish an infrastructure to ensure that educational and governance activities are properly coordinated and reflect the individual and service needs. A comprehensive induction programme should be in place, and staff should have regular appraisal so that the gap between what they know and what they need to know to deliver effective, quality care can be bridged. Furthermore, organisations have to make knowledge available to staff by using appropriate modern technology.

If organisations have to invest in their staff and provide access to knowledge, clinical teams and individuals need to be aware of their skills and skills gap so that training can be targeted appropriately.

This issue deals with knowledge management, which has been defined as<sup>2</sup>:

recognising the importance of knowledge and mobilising it in a form that professionals can apply.

And as<sup>2</sup>:

[the] creation of a coherent system for producing, analysing, synthesising and using knowledge to effect positive changes to enhance performance and to make efficient use of human and financial resources.

Articles in this issue cover the National Electronic Library for Health, the use of learning sets to further professional development, and a multi-agency approach to further the clinical governance

### Topics for future issues

- Communication and teamwork
- Clinical error
- Clinical incidents and complaints

Please share your practical examples with us, and email them to the Editors:  
mlugon@compuserve.com  
gscally@doh.gov.uk

### In this issue

- 1 Editorial: Knowledge management
- 2 The National electronic Library for Health (NeLH) – ‘gold standard’ knowledge for the NHS
- 4 Networking for the management of health-care risk: the Healthcare Risk Forum learning sets
- 6 Providing multi-agency work-based education for clinical governance
- 8 Top tips on knowledge management
- 9 WhoWhatWhere?
- 10 A simple traffic light monitoring system to measure progress in clinical governance
- 12 Establishing a multi-disciplinary approach for children with learning difficulties



The ROYAL  
SOCIETY of  
MEDICINE  
PRESS Limited

agenda, as well as top tips and websites on knowledge management. Further articles on this topic will be published in future issues.

To date, we have kept to a thematic approach for the *Bulletin*. From this issue we will use a topic as a main theme, but include articles on topics that may have already been covered in previous issues. We are therefore including an article on the use of a traffic light system to

measure progress with the clinical governance agenda and another on how to establish a multidisciplinary approach for children with learning difficulties.

In the next issue we will deal primarily with communication and teamwork, but will also revisit topics we have previously covered. Later on this year we will cover clinical incidents and complaints. We invite you to submit contribution to the *Bulletin*

about your practical experiences in the field of clinical governance, highlighting key learning points so the lessons learnt in the process can be shared with the wider NHS.

#### References

- 1 *Continuous Professional Development*. London: Department of Health, 1999
- 2 Wyatt J. *Clinical Knowledge and Practice in the Information Age: A Handbook for Health Professionals*. London: RSM Press, 2001

## The National electronic Library for Health (NeLH) – ‘gold standard’ knowledge for the NHS

**Shane Godbolt**

Head, London Library and Information Development Unit, 20 Guilford Street, London WC1N 1DZ, email [sgodbolt@lidiu.ac.uk](mailto:sgodbolt@lidiu.ac.uk)

- The National electronic Library for Health (NeLH) offers easy access to best current knowledge and information. It thus helps individuals and teams to access up-to-date information.
- It supports clinical governance and lifelong learning by making it easy for NHS staff to access relevant information pertaining to their practice.
- The NeLH is equally open to all NHS staff and users.
- The information is available via the Internet and NHSnet, which allows for quick access.
- This development has fostered partnership between NHS clinical staff and librarians, who can help staff to navigate the system.

### Background

‘Doctor doesn’t know best’ proclaimed the *Daily Mail* headline (19 July 2001) when the Bristol Royal Infirmary report was published. Despite this and other media hype, knowing what is known is a challenge for anyone needing to integrate the use of reliable information with their daily working practice. Forces of fundamental change – health-care reforms, the consumer movement and the ubiquity of networked information – are radically affecting the environment in which the NHS operates.

Investment in modern information systems to produce better information for better management of resources is core to policies for managing costs and improving the quality of health and social care services. This investment is also key to supporting the agenda for clinical governance and embraces the integration of knowledge with the electronic patient record.

### Vision

The idea of ‘knowledgeable patients advised by knowledgeable professionals supported by accurate and up-to-date information and information technology’<sup>1</sup> is core to the government’s vision for the NHS. Three years ago, *Information for Health*<sup>2</sup> set out the strategy for putting in place the infrastructure to implement a networked culture for the NHS which would facilitate achievement of its health and health-care objectives. The National Electronic Library for Health (NeLH), with its strong NHS branding, is a key element of that strategy:

There is now an opportunity to begin to develop from scratch an NHS accredited National Electronic Library for Health.<sup>2</sup>

### Aims and purpose

The NeLH, still in its pilot phase but nonetheless impressive, aims to

ensure that all involved in receiving, delivering or managing health-care have access to the right information at the right time and in the right place, be that hospital ward, community clinic, bedside, home or surgery. The NeLH mission is:

to improve health and healthcare, clinical practice, patient choice and patient influence on the NHS by providing easy access to best current knowledge and information.

Earlier this year, *Building the Information Core*<sup>3</sup> updated the strategic objectives of *Information for Health* in response to the priorities identified in the *NHS Plan*<sup>4</sup>. The NeLH sits firmly within the modernisation agenda:

The NeLH is one of the central elements.... It will deliver high quality information quickly for both professionals and patients and form a key part of a network of knowledge and information management services.... knowledge shared between all different members of the healthcare community – patients and public alike – will guarantee that patients and the public are better placed to make constructive comment and conscious decisions on the future of health services, while professionals are supported in implementation of Clinical Governance, and lifelong learning for both professionals and managers.

The NeLH achieves benefits for the NHS by:

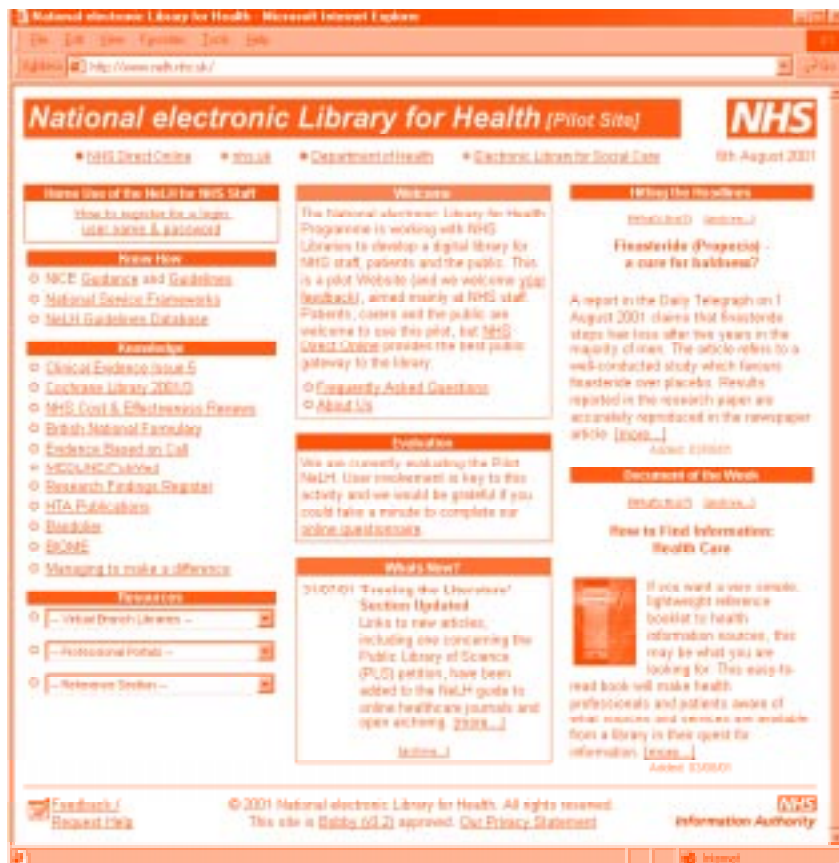


Figure 1. The NeLH homepage (<http://www.nelh.nhs.uk>).

- making information about the effectiveness of care readily available to all NHS staff and users;
- using Internet and associated technologies to deliver evaluated information which is accessible from any Internet-enabled PC in the workplace, library or at home.

### Development of the NeLH

Key principles which guide the NeLH programme are:

- obsession with the quality of knowledge;
- focus on knowledge and the skills required to apply it;
- equal access for patients and clinicians;
- commitment to create and sustain communities of users (through virtual branch libraries and professional portals – see below);
- seamless access to the NeLH from NHS Direct Online (<http://www.nhsdirect.nhs.uk/>), which was originally the ‘patient floor’ of the NeLH but, now with a separate identity, is the primary point of entry for members of the public

to quality-assured knowledge about health and health-care.

Further information on the purpose and future development of the NeLH is available from the ‘Frequently asked questions’ section (<http://www.nelh.nhs.uk/faq.asp>).

### Pilot site content

The pilot NeLH site was launched late last year (Figure 1). It is gradually building on existing resources, including items with which most readers will be familiar – the Cochrane Library, *Clinical Evidence*, guidelines from the National Institute for Clinical Evidence (NICE) and *Bandolier*. There are also entirely new products and services, such as ‘Hitting the headlines’, which provides evidence-based assessments in response to topical health stories in the press and which should prove a valuable counter to media hype.

The NeLH gives information support for national priorities and programmes, including the National Service Frameworks. For example, the coronary heart disease zone

(<http://www.nelh.nhs.uk/heart/>) provides links to information on rapid-access chest pain clinics and other supporting resources.

New resources are added regularly. May 2001 saw the addition of the Evidence Based On Call and Medendum e-guidelines databases.

### Branches and portals

One of the goals of the NeLH is to create communities of users known as virtual branch libraries (VBLs). These bring together multi-professional and other groups, and may include patients as well as staff working in a particular specialty or on a specific health issue.

While all specialties are represented on the NeLH site, they are at different stages of development. A well developed example is the Centre for Evidence Based Mental Health Electronic Library (<http://www.psychiatry.ox.ac.uk/cebmh/elmh/nelmh/>).

Professional portals are the latest innovation on the NeLH. These aim to serve the information needs of specific professional groups. An example is the portal for speech and

language therapists launched in April this year at the Royal College of Speech and Language Therapists' national conference.

### Librarians and the NeLH

It has been a principle from the inception of the NeLH that it must be coherent with the wider development of library and knowledge services for NHS users, and needs to be integrated with local information on local intranets. Simply developing and launching an electronic library does not in itself bring about change. The role of expert librarians and information specialists is changing to meet the needs and opportunities generated by a knowledge-based health service. Currently, for example, health librarians are working as:

- members of clinical teams to support development of guidelines and care pathways;
- trainers in information literacy skills;
- content developers and organisers of information for intranets.

Two typical comments from librarians illustrate the value of the NeLH:

I certainly include NeLH in any Internet sessions that I do ... the FAQ page is very helpful for first-time users. (Michelle Hutton, Electronic Information Skills Librarian, West London Workforce Development Confederation)

NeLH ... is particularly useful in highlighting some of the newer or less used resources, especially Cochrane, webBNF and *Clinical Evidence*.

Despite lots of previous promotion of Cochrane, now that people are shown it as part of a collective resource they seem more eager to use it... All in all, it's a great resource for training as it's just one address for people to remember and gives them the opportunity to try out some of the extra links.

(Julianne Watson, Clinical Support Librarian, Forest Healthcare NHS Trust)

Do contact your local librarian if you have not yet seen or used NeLH services.

### Getting involved

There are many opportunities for users to contribute to the further

development of the NeLH. Currently, the NeLH team is seeking to build a user advisory panel, encompassing all professional groups and societies. The panel will work electronically and will be expected to contribute by responding to a short set of questions three or four times a year. The NeLH is a core tool for clinical governance, and the panel will give a genuine chance to contribute to it.

The NeLH is about harnessing our vast health knowledge base in the service of patient care<sup>5</sup>. The stakes in human and financial terms are high if we do not exploit this brilliant vision effectively.

### References

- 1 Department of Health. *The New NHS: Modern, Dependable*. London: HMSO, 1997
- 2 NHS Executive. *Information for Health. An Information Strategy for the Modern NHS*. London: NHS Executive, 1998
- 3 Department of Health. *Building the Information Core: Implementing the NHS Plan*. London: Department of Health, 2001
- 4 Department of Health. *The NHS Plan*. London: Stationery Office, 2000
- 5 Hicks A. From virtual to reality: the development of the NeLH. *IFMH Inform* 2001;12:1-3

## Networking for the management of health-care risk: the Healthcare Risk Forum learning sets

### Hilary Merrett

Director of Education, St Paul/Healthcare Risk Resources International, 61-63 London Road, Redhill, Surrey RH1 1NA, email hilary.merrett@stpaul.com

- **Multidisciplinary learning sets provide a confidential environment in which to learn and share experience; this is of benefit to the health-care organisation.**
- **Both participants and organisations can gain most out of sets which run over a prolonged period of time and evolve.**
- **The success of learning sets depends on the commitment of the participants and good facilitation.**
- **Learning sets with a single-topic work programme can offer a forum to further education in a particular field, such as clinical risk management.**

- **The Healthcare Risk Forum learning sets have helped individuals identify steps to establish secure, sound risk management and thus have helped organisations in the implementation of robust clinical risk management processes.**

Many managers from all walks of life have found that joining a learning set can be a positive and influential step in their personal and professional development. There are many senior clinical managers and executives in the NHS who have belonged to such sets for years. The value of their membership over the years changes in nature but usually grows in degree.

### Background

The purpose of a learning set is to provide a confidential learning environment for a small group of people who share occupational challenges and who normally are operating at similar levels within their working lives; they may also share personal and professional aspirations. Successful learning sets depend on the establishment of positive and lasting relationships between members.

Depending on the experience of the group facilitator, his or her role may have a mentoring or coaching facet. Most importantly, however,

the facilitator must be skilled in small-group work and be focused on the positive development of group identity and cohesiveness.

While there are no hard-and-fast rules for the make-up of sets, they usually comprise between four and six members with one facilitator. Smaller numbers make the group vulnerable if one or more members drop out and larger groups may lose the intimacy necessary for a productive learning environment.

### The Healthcare Risk Forum learning sets

In order to support health-care organisations in achieving sound clinical risk management, learning sets were set up as part of the Healthcare Risk Forum, a membership network created for organisations with an interest in health-care risk management. The Forum is run by Healthcare Risk Resources International (HRRI) and aims to help health-care organisations address some of the challenges of providing safe and effective services in a demanding environment.

The Forum has been running since 1998 and comprises three main features:

- a network of information resources, meetings and seminars;
- educational opportunities;
- access to a package of professional consulting services, as chosen by the member organisation.

Part of the network services is access to a confidential learning set. All member organisations are invited to nominate someone to join a learning set – these are groups of five to six people, facilitated by one of HRRI's members of staff. They meet four times a year and set their own agenda to meet both their own personal development needs and to solve problems they share in their professional lives.

There are now about 20 risk and other managers who are or have been members of these groups over the past two or three years; some have a clinical background. This has proven to be one of the most successful and popular dimensions of the Forum and many members make arrangements to continue membership even after leaving their organisation.

The first meetings were an opportunity to make introductions

and to set some broad objectives. The following are examples of the types of objective that might be considered:

- *work objectives* – for the benefit of a member's organisation;
- *personal and professional objectives* – for the benefit of the set members' personal and professional development;
- *set objectives* – for the benefit of the set members collectively.

In order to develop trust and confidence, some ground rules were required regarding:

- the quorum for the set;
- entry and exit rules;
- confidentiality;
- the frequency of and venues for meetings.

Over the first few meetings it became clear which members were serious about their role in the group; it may not work for some and the set must be clear about how to handle these situations.

The learning sets offered a development mechanism rooted in members sharing experiences with and offering support to others, as well as gaining information for themselves. The learning set environment has helped individuals to solve specific problems

but the skills, experience and knowledge to aid problem solving will come through a meeting of minds.

Once a set has established a positive and comfortable environment for its members, based on trust, specific case studies of problems become the focus for meetings for a time, helping the individual members of the set to learn from the experience of others in a safe environment.

### Benefit of the learning sets in clinical risk management

The development of learning sets specifically aimed at managers and clinicians has yielded specific benefits. The efforts of risk management and risk managers focus on structures and processes for improving patient safety and reducing the opportunity for claims, complaints and dissatisfaction.

The learning points which have emerged for participants in this sort of approach include:

- understanding better the nature of one's role within the organisation;
- networking with peers in a 'safe' environment, away from the everyday demands of their jobs;
- mutual support and encouragement;

## Contributions

*Clinical Governance Bulletin* is a publication for clinicians and managers working in trusts, health authorities and PCGs and aims to communicate practical examples, pool shared experience and highlight and disseminate best practice on a broad range of issues in health management. Topics covered include the following, with each issue taking one area as its main theme:

- Patient experience
- Clinical effectiveness
- Resource effectiveness
- Communication
- Risk management
- Effective teamwork and learning
- Effective strategy
- Clinical information

Contributions that are practical and relevant to everyday practice are welcomed. They should be 500–800 words in length, with a maximum of five references in Vancouver (numerical) style. Please send your contribution, by post (with floppy disk) or email, to one of the Editors:

Dr Myriam Lugon, Editor, *Clinical Governance Bulletin*, c/o Royal Society of Medicine Press Limited, 1 Wimpole Street, London W1G 0AE (email [MLugon@compuserve.com](mailto:MLugon@compuserve.com))

Dr Gabriel Scally, Regional Director of Public Health, NHS Executive South West, Westward House, Lime Kiln Close, Stoke Gifford, Bristol BS34 8SR (tel. 0117 984 1810, fax. 0117 984 1841, email [gscally@doh.gov.uk](mailto:gscally@doh.gov.uk))

- enhancing knowledge of specialised managerial or clinical issues;
- learning about good and best practice elsewhere, through sharing policies and protocols and guidelines (i.e. avoidance of wheel reinvention);
- exploration of strategies for managing difficult clinical risk management issues through discussion of cases and scenarios;
- planning career progression, personal development and enhancing opportunities by comparing notes on career development;
- undertaking focused group research and comparative analyses on specific risk management topics.

Specific achievements of the sets include:

- the establishment of best practice in running risk management committees;
- the compilation of a policies and protocols register;
- presentations at national conferences on clinical risk;
- the benchmarking of costs in negligence claims.

Most recently, groups have started to host meetings at each other's organisations to combine an in-depth look at other organisations and an understanding of a local environment with the business of the learning set agenda. For example, one set has visited Northern Ireland

to gain an insight into the provision of community services for a divided community, visiting the estates of Protestant and Catholic north-west Belfast and touring the Parliament building at Stormont. It also visited the hospital on the Isle of Wight to gain an understanding of the problems of managing health-care for an island population.

## Conclusion

This experience has demonstrated the value of the learning set approach in providing a productive learning and supportive environment for risk managers. It has also shown that learning sets can be a valuable forum to provide training and development in the field of clinical risk management.

# Providing multi-agency work-based education for clinical governance

Angela Furne<sup>1</sup>, Fiona Ross<sup>1</sup>, Keith Holdaway<sup>2</sup>, Nizam Mohammed<sup>1</sup> and Sylvie Marshal-Lucette<sup>1</sup>

<sup>1</sup>Faculty of Health and Social Care Sciences (FHSS), Kingston University (KU) and St George's Hospital Medical School (SGHMS), 2nd Floor Grosvenor Wing, SGHMS, London SW17 0RE, email Angela.Furne@orc.co.uk; <sup>2</sup>Wiremill Associates

- Ownership of an education programme by key clinical governance decision makers, staff and educators means that education can be tailored to organisational needs and current context.
- Ensuring flexibility in the topic chosen will enhance staff participation, as will a financial incentive to attend.
- Effective communication between education consultants and key decision makers – which includes agreed objectives, roles and responsibilities and constant evaluation – is key to working in partnership and is essential to the success of a comprehensive training programme.
- Organisational ownership of the nature of staff education encourages both the implementation of staff learning and the rapid evaluation of its implications.
- Clinical governance education is simply the beginning of the process of change. The test of its effectiveness is its implementation into daily practice by different

professionals working together in varied contexts.

## Background

For an NHS organisation to develop a framework through which it is accountable for continuously improving the quality of its services, it will require educational input at a number of levels and over a considerable period of time. Effective clinical governance is no quick fix. For education to be useful, it helps if it is designed in keeping with the pace of development of the organisation and if it can be flexible to the organisation's specific contextual needs. In addition, it is helpful if educational input can provide immediate results as well as movement towards both new cultures and the long-term strategic direction. Education programmes also provide a forum in which staff and managers can share views, skills and knowledge.

This article discusses a programme of education for clinical governance

which aimed to address these issues. South-West London and Epsom Education and Training Consortium (SWLEEC) commissioned the Faculty of Health and Social Care Sciences (FHSS) of Kingston University to run a series of workshops on clinical governance in partnership with local health organisations. The aim of the workshops was to provide customised and flexible opportunities for mixed professional groups to apply the principles of clinical governance to the workplace.

## Devising and delivering education workshops

All the local NHS organisations were approached, initially by letter informing them of the opportunity. On invitation by all interested organisations, an appointed facilitator visited key clinical governance decision makers to discuss and design an appropriate educational package, tailored to local needs. Workshops were devised and delivered by a team

of facilitators in partnership with 15 organisations (acute, community, primary care and mental health and learning disability trusts) between November 1999 and March 2001. Each organisation was offered three half-day workshops, for groups of 12–20 professionals, in or near the workplace, on clinical governance issues, in keeping with organisational development priorities. Each provider organisation was actively involved with facilitators in the planning, delivery and evaluation of their workshops, including:

- decisions on the professional and status mix of participants;
- topics to be covered;
- methods of learning.

Some workshops were run for mixed-agency groups that included housing and social services departments and the voluntary sector, while others were multiprofessional care groups, specifically primary care or hospital service professionals, and included nursing and medical staff and professions allied to medicine. Some workshops were devised solely for clinical governance leads regardless of profession, while others were devised for participants of all levels of seniority. All workshops centred on participatory small-group work, but also included plenary presentations, group discussion and brain storming, use of video and role play.

The learning topics included:

- What is clinical governance?
- What is the role of the clinical governance lead?
- Understanding change management.
- Understanding multidisciplinary/multi-agency teamwork.
- Project management and time management skills.
- Critical appraisal of the literature.
- Facilitating patient involvement.
- Risk management, audit and clinical effectiveness.
- Practice and professional development plans.
- Sharing good practice and dealing with poor performance.

### Practical lessons, benefits and limitations

Attendance was good and excellent where a financial incentive was provided.

The programme achieved its overall aims – feedback suggested that participants appreciated the opportunity to network, to learn the basics of clinical governance, including its component parts, as well as to devise action plans on some or all of the areas covered and on occasion to work on small-scale achievable projects to implement change in the workplace.

Because the project was innovative, many lessons were learned regarding the management of this form of educational intervention. For example, identifying and communicating with relevant decision makers, particularly in large, mixed-site organisations at times of rapid change, took patience and time but was absolutely necessary to gain full ownership of such an intervention.

Working in partnership with key decision makers to design a flexible learning programme to meet immediate organisational needs meant that facilitators could not be crystal clear immediately about what would be offered; although this was sometimes frustrating, it was necessary.

A bespoke advertisement flyer identified key aims of the project and the limits to its flexibility, to reduce potential anxiety over the ‘openness’ of such a programme. Appointing one key facilitator to an organisation for the duration of the project facilitated responsive communication and decision making. In particular, arranging one face-to-face meeting with all stakeholders to design and agree the format worked best.

A bespoke project-management sheet identifying roles, responsibilities, timetable and intended outputs was also to be agreed by the facilitator and the key contacts in the health provider organisation. Partnership working facilitated the management of shifting expectations, as some organisational contexts changed rapidly during the education intervention.

Setting dates in advance for the whole series of workshops proved more successful than a flexible approach to planning sessions. In particular, it gave time:

- to send out programme details to participants before each session;
- to discuss the programme’s content and to make alterations to the agenda if required;

- to invite an expert to address the group.

In order to generalise the experience, facilitators worked as a team in preparing, delivering and evaluating sessions, and aspired to allocate and then share expertise in a particular aspect of clinical governance (e.g. patient involvement, risk management, clinical effectiveness, professional development). Unfortunately, geographical separation of working partners and restricted time on any one particular project limited their success.

For staff, competing priorities of mandatory staff training meant recruitment and retention were sometimes challenging. Where the provider organisation was ‘signed up’ to the workshop design and participated in all sessions, best attendance was achieved. The provision of a financial incentive helped to recruit and retain general practitioners in particular, and written feedback on the sessions provided by the facilitator was helpful to assist participants with reflection on learning.

### Conclusion

The education programme was broadly successful in meeting its overall aims. It provided a learning experience for the educators and NHS managers as well as the participants. However broad-ranging, a short series of half-day workshops with a selection of participants from a number of organisations cannot do justice to the wealth of demand rising from the clinical governance agenda.

Education is backstage preparation for the daily public work of dealing with patients and modifying creatively the principles of putting learning into practice on a regular basis. For this to succeed, it is likely that a continued partnership between educators, organisations and employees is required.

For more details of this innovative education programme please contact: Fiona Ross, Professor of Primary Care Nursing, FHSS, 2nd Floor Grosvenor Wing, SGHMS, London SW17 0RE; or Angela Furne, Consultant in Employee Research, Opinion Research International, Angel Corner House, Islington High Street, London NW1, email [Angela.Furne@orc.co.uk](mailto:Angela.Furne@orc.co.uk).

# Top tips on knowledge management

## Jeremy Wyatt

Director, UCL Knowledge Management Centre, London, email [Jeremy.wyatt@ucl.ac.uk](mailto:Jeremy.wyatt@ucl.ac.uk)

Jeremy Wyatt is author of *Clinical Knowledge and Practice in the Information Age: A Handbook for Health Professionals*. London: RSM Press, 2001 (£12.95)

### Knowledge in general

- Knowledge is information that remains true across patients or cases – unlike patient data. Professionals need both kinds of information to achieve their goals effectively.
- Health-care is one of the most knowledge-intensive human activities and differs from commerce, so many insights from commercial knowledge management do not apply and many of the software products are inappropriate.
- The knowledge underlying skills and intuition is often tacit and not easily written down. To communicate tacit knowledge requires person-to-person contact through planned meetings or chance conversations – which may be brief (e.g. in the coffee room) or more extended (e.g. on secondment, as an apprentice, or in a community of practice).
- Explicit knowledge is found in documents such as books, guidelines, bibliographic databases or on the Internet. To mobilise it, you need to provide access to these documents or to disseminate extracts, for example in newsletters.
- The ‘evidence’ referred to by evidence-based practitioners is only one kind of knowledge – most usually about what works and what does not. The *Cochrane Library* and the British Medical Journal’s *Clinical Evidence* provide reliable sources of such knowledge.

### Knowledge management

- The purpose of knowledge management is to narrow the gap between what we know and what we do.
- Start your knowledge management programme by focusing on common but well defined clinical problems.
- Managing tacit knowledge means encouraging person-to-person

contact, while managing explicit knowledge means encouraging person-to-document contact.

- Understanding your organisation’s explicit knowledge needs, sources, and the formats likely to prove useful should precede and accompany intranet or website development.
- Regular application of a few ‘nuggets’ of knowledge by many professionals will lead to greater change than allowing the few to access the whole world’s literature.
- To ensure strategic fit, align your knowledge management programme with your organisation’s clinical governance, risk management, human resources and information activities.

### Clinical innovation

- Remember that disseminating printed or electronic documents may improve knowledge but will rarely change clinical practice<sup>1</sup>. You need to use evidence and guidelines as the foundation of appropriate methods of innovation.
- Clinical innovation means understanding barriers to change, then predisposing people to change, enabling change and reinforcing it using appropriate methods based on sound knowledge<sup>2</sup>.
- Which innovation methods are effective will depend on individual, peer group and organisational barriers, but can include patient information, audit with personal feedback, checklists, reminders, educational visits, identifying and involving opinion leaders, and small-group training sessions.
- A systematic review of over 100 innovation trials by Davis *et al.*<sup>3</sup> has shown that you are twice as likely to succeed in changing clinical practice if you carry out a study of local barriers or use three or more methods for introducing innovation.

### Realising a knowledge management programme

- Organisations need to recognise their knowledge needs and assets, and to change their culture so that knowledge is mobilised and applied, and individuals are encouraged to seek the knowledge they lack.
- Successful knowledge management means establishing a *culture* in which knowledge is valued, shared and applied to reduce knowledge inequality – information and communication *technology* come second.
- Librarians and their resources are key assets, who should be involved in all knowledge management discussions and activities.
- All knowledge management programmes should address the issues of balance, ethics and quality. For example, patients and carers should be empowered as well as health professionals; log files of who used documents should be kept confidential; opinion, policy and evidence all need to be distinguished; the risks of commercial sponsorship should be carefully assessed.
- Ensure that your organisation rewards knowledge donation, sharing and seeking, avoids elitism and discourages undue reliance on memory.

### References

- 1 Freemantle N, Harvey EL, Wolf F, Grimshaw JM, Grilli R, Bero LA. Printed educational materials: effects on professional practice and health care outcomes. *The Cochrane Library*, issue 3. Oxford: Update Software, 1999
- 2 Wyatt JC. Knowledge for the clinician 3. Practice guidelines and other support for clinical innovation. *Journal of the Royal Society of Medicine* 2000;93:299–304
- 3 Davis DA, Thomson MA, Oxman AD, Haynes RB. A systematic review of the effect of continuing medical education strategies. *Journal of the American Medical Association* 1995;274:700–5

# WhoWhatWhere?

## Knowledge management on the web

### Associations

British Medical Informatics Society (BMiS)

<http://www.bmis.org/>

see Editors' choice

International Medical Informatics Association

<http://www.imia.org/>

One of the goals of this organisation is to 'move informatics from theory into practice in a full range of settings, from physician's office to acute and long term care.'

American Medical Informatics Association

<http://www.amia.org/>

A non-profit membership organisation of individuals, institutions and corporations dedicated to developing and using information technologies to improve health-care.

Knowledge Management Centre, University College, London

<http://www.ucl.ac.uk/kmc/>

Mission statement: 'to improve clinical practice, patient outcomes and health service innovation and efficiency by formulating insights into the impact of communication and information technology ... promoting better health knowledge management by serving as a resource centre and making efficient use of our resources internally and across a network of collaborators.'

Medical Informatics Group, University of Manchester

<http://www.cs.man.ac.uk/mig/index.html>

This group is concerned with all aspects of the design and implementation of health-care information systems, especially those intended primarily for use as a clinical tool.

### Journals

*Medical Informatics & The Internet in Medicine*

<http://www.tandf.co.uk/journals/tf/14639238.html>

## The Editors' Choice

British Medical Informatics Society (BMiS)

<http://www.bmis.org/>

Mission statement: 'our purpose is to advance the knowledge and application of medical and health informatics, understood as the skills and tools that enable the sharing and use of information to deliver healthcare and promote health.'

*He@lth Information on the Internet*

<http://www.hiotti.org>

*Journal of Telemedicine and Telecare*

<http://www.rsm.ac.uk/pub/jtt.htm>

*Telemedicine Journal and E-Health*

<http://www.liebertpub.com/TMJ/default1.asp>

### Books

*Clinical Knowledge and Practice in the Information Age*, by Jeremy C Wyatt (2001)

<http://www.rsm.ac.uk/pub/bkwyatt.htm>

*Guide to Healthcare Resources on the Internet*, by Robert Kiley (2001)

<http://www.rsm.ac.uk/pub/bkkiley2.htm>

*Managing Knowledge in Health Services*, edited by Andrew Booth and Graham Walton (2000)

<http://www.amazon.co.uk>

*Medical Informatics: Computer Applications in Health Care and Biomedicine*, edited by Edward Hance Shortliffe (2000)

<http://www.springer-ny.com/>

*The Doctor's Internet Handbook*, by Robert Kiley (2000)

<http://www.rsm.ac.uk/pub/bkkiley.htm>

*Medical Information on the Internet*, 2nd edition, by Robert Kiley (1999)

<http://www.harcourt-international.com/catalogue/>

*Guide to Medical Informatics, the Internet and Telemedicine*, by E Coiera (1997)

<http://www.arnoldpublishers.com/Scripts/webbook.asp?isbn=0412757109>

*Handbook of Medical Informatics*, edited by J van Bommel and M A Musen (1997)

<http://www.springer-ny.com/>

*Introduction to Clinical Informatics*, edited by Patrice Degoulet (1997)

<http://www.springer-ny.com/>

### Why not email us your suggestions?

Why not email us your suggestions? If you know of any useful websites that you would like us to mention in *Clinical Governance Bulletin* please email [kirsty.orriss@rsm.ac.uk](mailto:kirsty.orriss@rsm.ac.uk).

*Clinical Governance Bulletin*  
© 2001 The Royal Society of Medicine Press Limited. Apart from any fair dealing for the purposes of research or private study, or criticism or review, as permitted under the UK Copyright, Designs and Patents Act, 1988, no part of this publication may be reproduced, stored, or transmitted, in any form or by any means, without the prior permission in writing of the publishers.

# A simple traffic light monitoring system to measure progress in clinical governance

**Peter D Lees and Katherine Fenton**

*Directorate of Clinical Development, Southampton University Hospital NHS Trust, Southampton SO16 6YD*

- **Implementing clinical governance in a large, complex organisation is challenging; ensuring consistency is even more so.**
- **A set of key performance indicators that can be easily measured can be used to record the progress of individual teams or directorates.**
- **Monitoring progress using a traffic light system can help the organisation to identify where it needs to provide support and facilitation.**
- **Energy needs to be spent to ensure achievements are sustained.**

Clinical governance naturally embraces a broad spectrum of quality, neatly subclassified under seven components:

- evidence-based practice
- clinical risk
- research and development
- lifelong learning
- professional self-regulation
- user involvement
- clinical information

The objective is to improve quality incrementally over time. However, demonstrating improvement over a broad range of measures and across large and complex organisations is not easy.

**Table 1.** Examples of key performance standards

Key performance standard	Target and date	Lead responsible
All trust-wide audits will result in the audit cycle being completed, action plans drawn, implemented and re-evaluated	March 2001	Clinical effectiveness lead
Investigations of serious incidents will result in action plans being put into place. Robust monitoring systems must be established in accordance with the serious-incident policy	100% by March 2001	Head of risk management
There will be half-yearly increases in the number of clinical incidents reported against defined targets in the medium term	10% increase per year	Head of risk management
All directorates can demonstrate effective research and development peer review systems, including comprehensive monitoring and reporting mechanisms	100% by March 2001	Director of Research and Development

## The SUHT approach

The Southampton University Hospital Trust (SUHT) is a large acute teaching hospital trust employing over 4000 front-line clinical staff.

Its 14 clinical directorates provide district general hospital services to a local population of 500,000 and a number of tertiary services to a population of 3 million. The trust has modelled its strategy on the seven components ('pillars') of clinical governance with a corporate lead for each. Directorates have identified clinical governance leads and many have also nominated individual leads for the seven components. Within each component, a range of performance indicators (key performance standards) has been defined; from these the first year's targets were distilled and agreed with directorates (Table 1).

A simple traffic light system was developed to record progress against the key performance standards, which would be reviewed every six months at the biennial reviews of the trust business plan. Each key performance standard for each directorate was scored independently by the 'component' lead and the directorate. Where they agreed, that

## Editorial Committee

### Editors

- **Myriam Lugon**, Consultant, Clinical Governance and Health Care Policy, London
- **Gabriel Scally**, Regional Director of Public Health, NHS Executive South West, Bristol

### Other members

- **Aidan Halligan**, Director of Clinical Governance for the NHS, Leicester
- **Rosemary Hittinger**, Visiting Researcher, Management School, Imperial College of Science, Technology and Medicine, London
- **Susanna Nicholls**, Medical Support Physician, Procter and Gamble
- **Steve O'Neill**, Communications Manager, NHS Clinical Governance Support Team, Leicester
- **Clare Perkins**, Public Health Specialist, Liverpool Health Authority
- **Jonathan Secker-Walker**, Senior Lecturer, Department of Clinical Governance, University of Wales College of Medicine, Cardiff
- **Kieran Sweeney**, Lecturer in General Practice, University of Exeter

	Key performance standards (internal clinical governance standards)								
	1	2	3	4	5	6	7	8	9
Directorate 1	Red	Amber	Amber	Amber	Red	Red	Amber	Red	Red
Directorate 2	Green	Red	Amber	Green	Red	Amber	Green	Green	Amber
Directorate 3	Red	Amber	Amber	Red	Amber	Amber	Red	Green	Green
Directorate 4	Green	Green	Red	Green	Green	Amber	Green	Green	Green
Directorate 5	Amber	Green	Red	Amber	Amber	Amber	Amber	Green	Green
Directorate 6	Red	Green	Amber	Green	Amber	Red	Amber	Green	Amber
Directorate 7	Red	Amber	Red	Green	Amber	Amber	Amber	Green	Amber

Key

Green	Systems and/or processes in use
Amber	Systems and/or processes under development
Red	No systems or processes in use

**Figure 1.** A matrix of the performance of a trust's position against its own clinical governance standards.

The overall position of the organisation is fairly evenly spread across the three categories of red, amber and green, but with a slight preponderance for amber. By inspection of the vertical and horizontal axes, the trust can discover where to concentrate its efforts.

Looking at the horizontal axis, it is clear that Directorate 1 needs close attention. By contrast, Directorate 4 knows where to target its efforts to achieve green status overall.

Looking at the vertical axis, it is clear that the lead for standards 3 and 6 have problems, which may be a performance issue but equally may reflect a corporate issue, such as inadequate investment in a particular area. Equally, performance in standard 8 is generally so good that there are likely to be transferable lessons for standard 1.

'score' was accepted. Where there was disagreement, arbitration was provided by the Trust Clinical Governance Steering Group.

The results were then presented in a simple matrix, with directorates along the vertical axis and the key performance standards on the horizontal axis (Figure 1). This mode of presentation enabled three simple but valuable visual assessments to be made.

- Looking at the whole picture, a predominance of one or other colour is immediately obvious and gives an impression of the overall performance of the trust against its own standards.
- Directorates can assess their performance by looking along the horizontal axis and compare their performance to their peers. They can also see at a glance where they need to focus attention to

achieve green status by the end of the year.

- Component leads, using the vertical axis, can obtain a quick assessment of performance for their specific component of clinical governance. They can thereby single out directorates where specific help and encouragement are needed.

Finally, future comparison can be made over time by looking at consecutive charts. Again, comparison is possible at the three levels outlined above.

In the first year, targets were set and reviewed at the directorate mid-year business plan reviews (when the executives meet with individual directorates). Attention was concentrated upon red and amber lights, not forgetting to congratulate directorates for significant numbers of green lights. There was a significant

improvement over the year, with no red lights at the end and an increase in green lights from 27% to 53% (Table 2). The persistence of a significant number of amber lights is a concern and currently we are looking at how we can improve on this. We are also reviewing how realistic the original targets were for delivery in one year.

## Conclusion

This is a very simple method of demonstrating performance against internal clinical governance standards, which gives both in-year and between-year comparison. It offers in one diagram a picture of the performance of the whole trust, the individual directorate and the individual component of clinical governance. We have found it very helpful in managing both the clinical governance agenda and the process of biennial directorate business plan reviews.

Remaining challenges are the continued refinement of the traffic light scoring process, ensuring that 'green lights', once achieved, are sustained year on year and the continued development of the standards to ensure incremental improvement.

**Table 2.** Traffic light position comparing the beginning and the end of the financial year 2000/1

	Red	Amber	Green
April 2000	17 (10.3%)	103 (62.4%)	45 (27.3%)
February 2001	0	77 (46.7%)	88 (53.3%)

# Establishing a multidisciplinary approach for children with learning difficulties

**Amanda Kirby**

Medical Director, The Dyscovery Centre, 4A Church Road, Whitchurch, Cardiff CF14 2DZ, email [amanda.kirby@btinternet.com](mailto:amanda.kirby@btinternet.com)

- The integration of health, education and social services is necessary to support children with learning difficulties.
- Individual education plans can be used as the vehicle for monitoring the outcomes of therapy.
- Functional advice is often effective for children with minor learning difficulties.
- Job satisfaction and inter-professional learning have increased as a consequence of this multidisciplinary approach.

A lack of teamwork and integration between disciplines and sectors is not an uncommon problem in the NHS. In the case of children with conditions that are multifactorial in origin, such as Asperger's syndrome or developmental coordination disorder, however, the consequences can be particularly disturbing. Despite different therapists and health professionals residing under one roof, assessments are not carried out jointly and this results in information that is fragmented in both time, because appointments are often months apart, and person<sup>1</sup>. Information transfer and documentation are less than adequate, and repeated duplication of the child's history is often necessary. This is particularly frustrating when information from the school and educational psychologist has not been passed on before the consultation and is not passed back after it.

The spectrum of learning difficulty is often seen as low priority for children's services, despite the fact that there is a long-term risk of mental health problems in adulthood. In addition there is a lack of coordination between health, education and social services, which compounds the problem. The medical condition is usually perceived in isolation from the potential psychosocial impact on the child and family.

As a consequence of these shortcomings the Dyscovery Centre was set up in Cardiff three years ago. Its aims are:

- to assess the child holistically in the context of family and school<sup>2</sup>;
- to provide practical advice, equipment, toys and computer programs;
- to provide contact with support organisations.

In order to achieve these objectives, the Centre operates with a multidisciplinary team of health and educational professionals.

Before the first visit, an assessment form is completed by the parent, child and school, and any previous reports are acquired and added to the record. A team of health and educational professionals assesses the degree of difficulty and either allocates the child to the appropriate therapist(s), including a paediatrician and educational psychologist, or, if the difficulty is minor, provides telephone advice and/or an advice sheet. After consultation with the multidisciplinary team, a report and treatment programme are provided to fit in with both home and school. This rigorous multidisciplinary approach is particularly helpful in assessing the child's likely difficulties in real-life situations, such as those found in a busy classroom.

The child's individual educational plan (IEP) may be used as the

vehicle to deliver, assess and monitor progress with the personalised treatment programme.

Since the Dyscovery Centre became operational:

- parent satisfaction has improved;
- children's needs are being met in a more time-efficient manner;
- health and educational professionals' job satisfaction has increased;
- the opportunity for the multidisciplinary team to learn from each other has increased<sup>3</sup>.

This model has proved useful in relating 'health' difficulties in a language that the educational sector can understand.

## References

- 1 McConachie HR, Salt A, Chadury Y, McLachlan A, Logan S. How do child development teams work? Findings from a UK national survey. *Child Care, Health and Development* 1999;25:157-68
- 2 Wilson CK. Team behaviours: working effectively in teams. *Seminars for Nurse Managers* 1998;6:188-94
- 3 Boland J, Cann F, McCuaig L, Onslow D. Making team-working work - a real life experience. *International Journal of Language and Communication Disorders* 1998;33 (suppl.):570-4

## Subscriptions and enquiries

*Clinical Governance Bulletin* (ISSN 1470-9023) is published by The Royal Society of Medicine Press Limited, London, and is sent free to targeted health-care professionals working in the NHS.

Subscription prices for non-NHS in 2001 (six issues), including postage, are:  
**Institutional:** Europe £50, USA \$90, Elsewhere £52  
**Individual:** Europe £30, USA \$54, Elsewhere £32

Please address all orders and enquiries to Publications Subscription Department, The Royal Society of Medicine Press Limited, PO Box 9002, London W1A 0ZA, UK  
tel. +44 (0)20 7290 2927/8  
fax +44 (0)20 7290 2929  
email [rsmjournals@rsm.ac.uk](mailto:rsmjournals@rsm.ac.uk)

**Full text online: [www.clinical-governance.com](http://www.clinical-governance.com)**

This publication is funded by the Department of Health.